MFR Center Client Intake Form

Please fully complete the Intake Form below before your first session (works best from desktop or laptop).

Name *

First

Last

Email *

Cell Phone *

(201) 555-0123

Which therapist are you seeing for your first appointment? *

- ○ Frances
- ○ Tom
- ○ Michelle
- ○ Tabitha
- ○ Olga
- ○ Eric
- ○ Tana
- ○ Trevor
- ○ Kelley
- ○ Other

How did you hear about us?

- ○ Yelp
- ○ Google
- ○ Facebook
- ○ Referral
- ○ Other

Would you also like to be contacted by Frances for a combo session of MFR w/Guided Meditation? This significantly enhances both the physical and emotional releases that

come with Myofascial Release. *

- ○ Yes, please.
- ○ Not right now.

Mailing Address *

Address Line 1

Address Line 2

City

--- Select state ---

State

Zip Code

Date of Birth *

(MM/DD/YYYY)

Occupation *

Gender *

- ○ Female
- ○ Male
- ○ Other

Emergency Contact Name *

Emergency Contact Phone Number *

Have you ever received a John Barnes style MFR Session? *

- ○ Yes
- ○ No

- ○ I don't know

Communication with your therapist during your session is essential. Will you agree to be willing to communicate anything you are feeling, whether physical or emotional, to your therapist? *

- ○ Yes
- ○ No
- ○ Unsure

Will you agree to daily fascia stretches as suggested by your therapist? *

- ○ Yes
- ○ No

Current complaints/symptoms/issues: *

History of Injuries (including adverse reactions from any COVID treatments or medications): *

Any surgeries? *

Any diagnoses (including long-COVID)? *

Any conditions? *

Please explain any emotional traumas which may be contributing to your conditions. *

Bodywork Goals: *

If you answer "yes" to any of the following questions, please explain as clearly as possible in the additional comments section at the end of the list.

Do you frequently suffer from stress? *

- ○ Yes
- ○ No

Do you have diabetes? *

- ○ Yes
- ○ No

Do you experience frequent headaches? *

- ○ Yes
- ○ No

Are you pregnant? *

○ Yes ○ No

Do you suffer from arthritis? *

○ Yes ○ No

Are you wearing contact lenses *

○ Yes ○ No

Are you wearing dentures? *

○ Yes ○ No

Do you have high blood pressure? *

○ Yes ○ No

Are you taking high blood pressure medication? *

○ Yes ○ No

Do you suffer from epilepsy or seizures? *

○ Yes ○ No

Do you suffer from joint swelling? *

○ Yes ○ No

Do you have varicose veins? *

○ Yes ○ No

Do you have any contagious diseases? *

○ Yes ○ No

Do you have osteoporosis? *

○ Yes ○ No

Do you have allergies? *

○ Yes ○ No

Do you bruise easily? *

○ Yes ○ No

Any broken bones in the past 2 years? *

○ Yes ○ No

Any injuries in the past 2 years? *

○ Yes ○ No

Do you have tension or soreness in a specific area? Please specify in comments. *

○ Yes ○ No

Do you have cardiac or circulatory problems? *

○ Yes ○ No

Do you suffer from back pain? *

○ Yes ○ No

Do you have numbness or stabbing pains? *

○ Yes ○ No

Are you sensitive to touch or pressure in any area? Explain in comments. *

○ Yes ○ No

Have you ever had surgery? Explain in comments. *

○ Yes ○ No

Any other medical condition, or are you taking any medications we should know about? Explain in comments. *

○ Yes ○ No

Additional Comments: *

Referred by:

Consent to Treatment of Minor: By entering my name below, I herby authorize the therapist to administer bodywork techniques to my child or dependent as they deem necessary.

BY CLICKING THE SUBMIT BUTTON BELOW, I AGREE TO THE FOLLOWING:

I understand that the bodywork I receive is provided for the basic purpose of relaxation and release of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so the pressure and or strokes may be adjusted to my level of comfort. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialists for any mental or physical ailment of which I am aware. I understand that bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all my own medical conditions and answered all questions honestly. I agreed to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

☐ Send me a copy of my results!

Submit